New England Deaconess Hospital

Annual Report

1981

"The Deaconess is a special place. A warm, caring hospital in which the patient always comes first."

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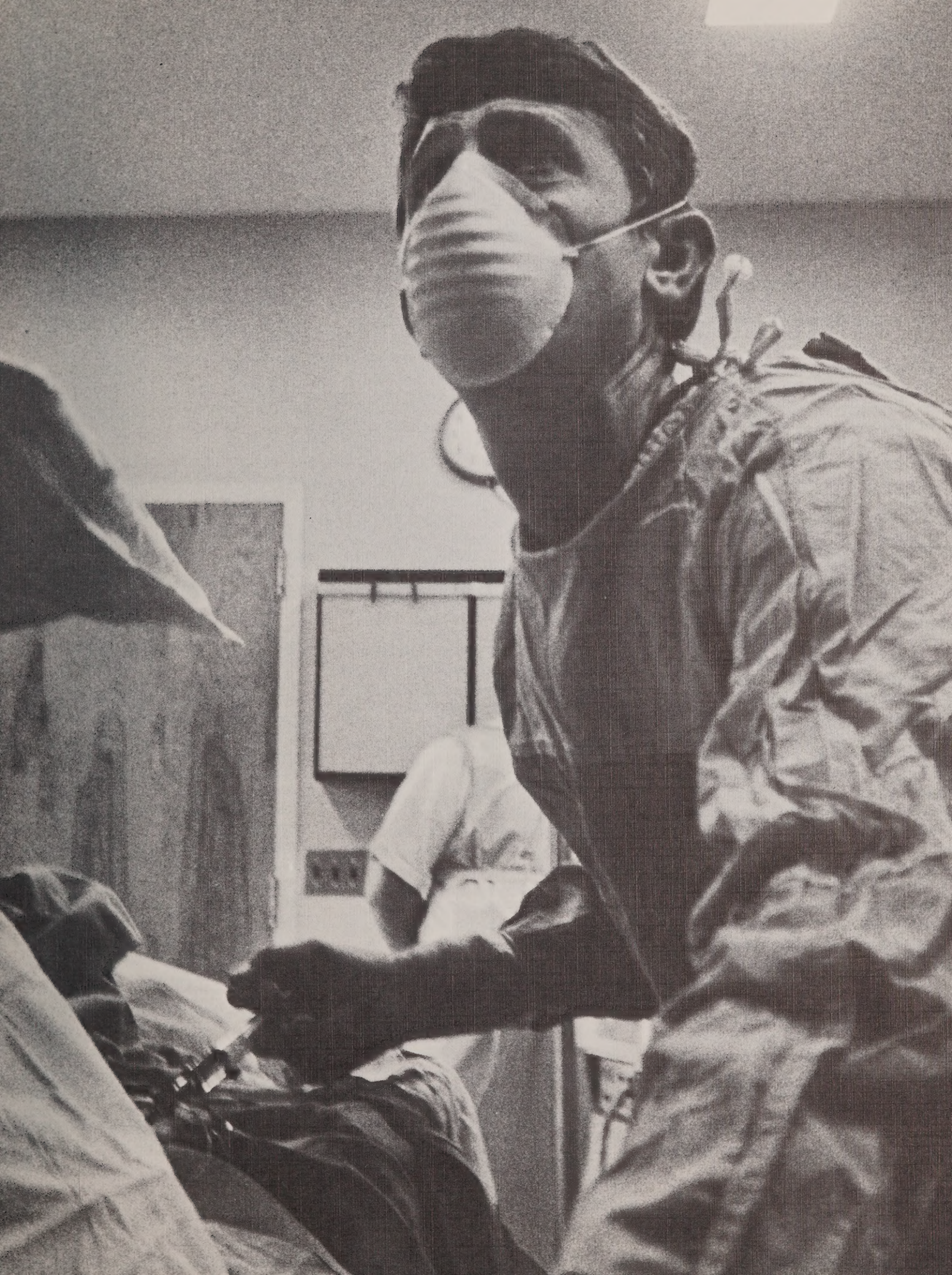
This report covers the New England Deaconess Hospital's fiscal year period of September 29, 1980 through September 27, 1981.



Report of Management

"Our hospital continues to be sound financially, has a strong management team and a dedicated medical staff."

The year 1981 has been a period of major transition for the New England Deaconess Hospital. On November 24, 1980, Lahey Clinic Medical Center opened its own 200-bed hospital in Burlington and, as a result, reduced its daily bed utilization at our hospital from approximately 135 to about 25. Fortunately, we had ample notice of this rather dramatic shift in demand and the obvious implications for our traditionally high occupancy levels. Therefore, starting more than a year ago, we began to selectively recruit doctors to fill the anticipated voids which would be created by the change in the clinic's focus. We are happy to report that, while occupancy was down somewhat, we managed to exceed our patient demand projections and to outperform our financial forecasts. Moreover, the hiatus enabled us to catch up on deferred maintenance and to complete several overdue renovation projects.

Fiscal 1981 started with very heavy demands on our staff during October and November, just prior to the opening of the Lahey Clinic Medical Center. This was followed by the traditional holiday slump at the end of December. Somewhat surprisingly, demand continued relatively strong during the winter and did not slow down until spring. In mid-August, utilization began to strengthen and that trend has continued into the fall.

Reflecting these trends, net operating revenues amounted to $82,888,693. After expenses of $82,946,426 and nonoperating income and expense, we ended the year with a surplus of $2,266,314. These results exceeded our expectations and are very gratifying in light of the many uncertainties we faced when fiscal 1981 began.

In April, the Deaconess received a Blue Ribbon Award from the New England Hospital Assembly for the effectiveness of its cost containment program. Estimated savings amounting to $625,000 during fiscal 1981 have come from: more efficient materials management techniques; less use of electricity, steam and chilled water throughout the hospital; a substantial reduction in our annual telephone bill; and an educational program designed to make our entire staff cost-conscious. Cumulative savings over the past 2½ years have exceeded $1.4 million.

While no major construction projects were initiated during the past year, the building committee was active. It supervised the refurbishing of three floors in the Palmer Building, the conversion of a floor-and-a-half in the Lowry Medical Office Building from motel units to physician offices, as well as the completing and equipping of three laboratories in the Cancer Research Institute's new wing which was opened in 1980. With a federal energy grant of $204,000 to help defray the costs, the Palmer renovations were started last December during the period of normally decreased demand for beds. The refurbishing included replacement of a 54-year-old elevator, new insulation and up-to-date temperature controls, all of which will save additional operating costs by making the Palmer Building more energy-efficient. In addition to these activities, the trustees approved the building committee's recommendation that the hospital's growing computer operation and related support services be relocated from their extremely congested location on the roof of the Deaconess Building to a new structure which will be erected between Palmer and Baker. We hope to start construction on this project around year-end 1981.

Looking ahead, we are putting increased emphasis on program and facility planning. Even though our total bed capacity may not increase significantly, we expect our clinical support services will expand as new technology and improved techniques are developed. Moreover, the Palmer and Baker buildings are 54 and 49 years old respectively, and their patient beds, obsolete by most modern standards, probably should be replaced. As a temporary measure to relieve pressure for space, the trustees approved the rental of 22,000 sq. ft. in the Red Cross building located less than one mile away from the Deaconess. While this move will enable us to relocate a number of nonclinical activities "off-campus" and will relieve the pressure for space for several years, it is not a permanent answer to our problems. Management, the chiefs of service and our long-range planning committee have spent a great deal of time during the past year examining various solutions to our future space and program needs. The next step in this process is likely to be the retention of outside consultants to review, refine and expand on our internal efforts leading to a concrete proposal for what needs to be done and how to finance it. Related to these long-range planning activities, our staff completed last year a major study, entitled "Strategy for the 80's," which establishes a set of objectives for the Deaconess to achieve during the next decade and a framework within which to move toward these goals.

We have had to live in an increasingly burdensome regulatory environment over the past 10 years. Despite the growth of bureaucratic controls, designed in many instances to contain health care costs, the costs of medical and hospital care have continued to increase at a rapid rate. Discouraged by past efforts to control by regulation, it appears the Reagan Administration is

Laurens MacLure, President
Marvin G. Schorr, Chairman

about to submit legislation designed to control costs by the introduction of competition between hospitals in much the same fashion that prices are established in the private business sector of the economy. Reflecting this trend, our new Blue Cross contract abandons the historic cost-based approach to reimbursement and substitutes an entirely new concept called MAC (Maximum Allowable Cost). Under the MAC formula, Blue Cross will establish a maximum reimbursement figure for each hospital in Massachusetts. Thus, if our hospital spends less money caring for Blue Cross patients than is allowed, we will be permitted to keep the difference. On the other hand, if we exceed our MAC, we will not be reimbursed for the excess. The new contract, therefore, provides a strong incentive for us to contain expenses.

On the state level, the Executive Office of Human Services budget has been cut rather drastically; there will be much less money to pay for care and for regulation. Meanwhile, the state legislature is considering an extension of last year's ceiling on hospital charges. This proposal would establish the new ceiling at 9.6% versus 11.5% a year ago. It may be that hospitals will find themselves facing the worst of all worlds in the years immediately ahead: continued regulation plus the introduction of competition, coupled with inadequate funding of federal and state health care programs. Clearly, the prospect of difficult times ahead requires us to do a better job in the management of our resources.

On June 22, Dr. Robert C. Moellering, Jr. succeeded Dr. James L. Tullis as chairman of the department of medicine. Dr. Tullis was our first full-time chairman of this department and served for 17 years. During this period, he rendered many valuable services to the hospital, the most important of which was the establishment of an outstanding residency program in medicine. He will be long remembered for his organizational skills, his productive research, and his advocacy of the highest standards of patient care.

During the year, three honorary trustees passed away: Dr. Carl S. Ell, Edward Dana and Frank McGowan. We will miss them very much. Bishop Edward G. Carroll retired as a trustee, having served the hospital for eight years. We wish him well and extend our gratitude for his contributions to the activities of our hospital.

This report would not be complete without acknowledgment of the retirement of James F. Farr as our chairman after 3 very eventful and busy years. Under his able leadership, we started an ongoing renovations program designed to modernize our oldest buildings, completed a major addition to the Cancer Research Institute, appointed three new clinical chairmen, and expanded our parking facilities. We are pleased that Jim is remaining on the board and continuing to play an active role as a trustee.

We approach fiscal 1982 with mixed emotions. Our hospital continues to be sound financially, has a strong management team and a dedicated medical staff. However, it is inevitable that a changing regulatory environment, increasing demands on our personnel, plant and equipment, coupled with reimbursement uncertainties, will challenge us severely.

The Deaconess is a special place, and as such, is fortunate to have a large number of people loyal to the hospital and concerned for its patients. We are truly grateful to them. We also wish to express our thanks to our trustees, our medical staff, our management and employees, as well as the Friends of the Deaconess for their assistance during the past year. Their continued support will be vital in meeting the challenges in the year ahead.

Marvin G. Schorr, Chairman

Laurens MacLure, President

Department of Medicine

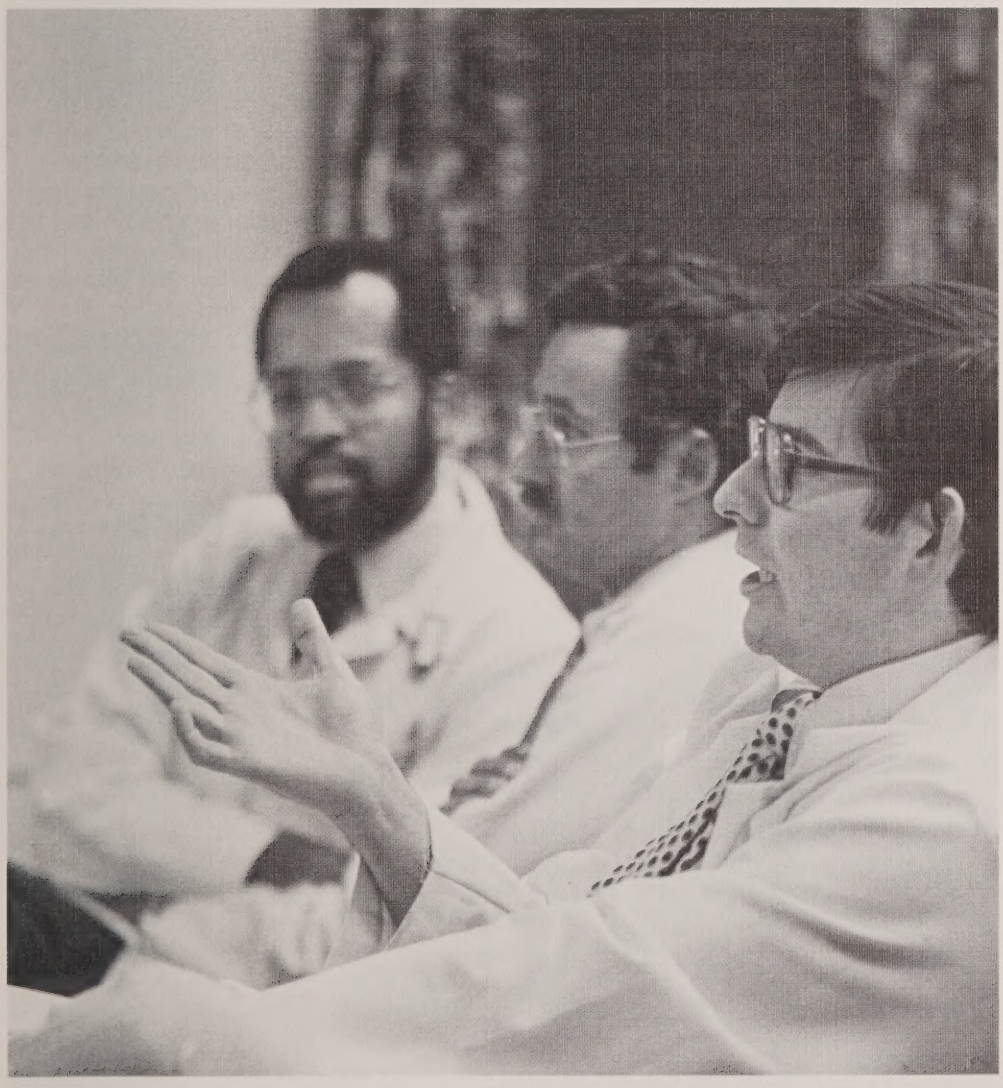
"... the central purpose of the department of medicine: to provide the best possible medical care for patients of the Deaconess Hospital."

The past year has been one of transition in the Deaconess Department of Medicine. In June of 1981, Dr. James L. Tullis retired after 17 years as department chairman. During his tenure, Dr. Tullis presided over a number of major medical advances. The residency program was established and, under his direction, it grew and prospered. Presently, there are more than 70 young physicians undergoing residency and fellowship training in internal medicine at the Deaconess, and in our affiliated programs at the Lahey Clinic Medical Center, Manchester (N.H.) Veterans Administration Hospital and the Chelsea Soldiers Home. The rotation of our house staff through these institutions provides them with a wide variety of medical experiences which complement their training at the Deaconess. The residency program continues to attract a large number of applicants each year from which a group of excellent physicians are chosen to provide both routine and emergency care for Deaconess patients.

Over the years, our residency program has resulted in many benefits for the patients and staff of the hospital. Residents give around-the-clock emergency coverage for all patients on the medical service, and work closely with staff physicians to insure that each patient receives the warm, personalized care for which the hospital is so widely known. The presence of these young, inquisitive physicians also has served as a constant source of stimulation for the senior staff members who serve as their instructors and, in so doing, constantly are encouraged to broaden their own scope of medical knowledge. Since they provide a fresh look at a patient's illness, house staff members commonly uncover new aspects which deserve special attention. Many of these young people have been encouraged to stay on as permanent staff members after completing their training. Consequently, this program has served as a source of talented, promising, new staff physicians for the hospital.

During Dr. Tullis's chairmanship, a number of prominent internists joined the Deaconess medical staff as private practitioners on the general staff, as members of the Joslin Clinic, or as members of Deaconess Medicine, a practice group organized by Dr. Tullis to serve the teaching and clinical needs of the department of medicine. Indeed, the Deaconess Hospital is unique among major teaching hospitals in having on its staff a very large number of excellent, private physicians who complement the activities of full-time hospital staff members. Their presence helps to assure the close doctor-patient relationship for which the Deaconess Hospital is recognized. Currently, there are nearly 180 internists who are members of the department, and among them are doctors with expertise in all of the major subspecialties as well as physicians specializing in primary care.

Although the department of medicine is fortunate to have a large number of excellent staff physicians, there are no plans to rest on past laurels. With support from the board of trustees, a number of new physicians will be recruited to provide even better clinical coverage in some subspecialty areas where more personnel are needed. Some of these physicians will be sought primarily for their clinical expertise, and will serve on the private staff. Others will be added to increase the teaching and research



capabilities of the department. The latter activities are particularly important because of current plans for closer affiliation between the department of medicine and Harvard Medical School. This closer association with Harvard will result in a number of overall benefits. The regular presence of bright, inquisitive medical students on the various patient floors of the hospital will be a constant source of stimulation for medical residents and senior staff who will be responsible for their instruction. In addition, the vast academic resources of the medical school will become more accessible to the staff of the Deaconess medical service.

Plans also are under way to increase the research capabilities of the department by recruiting and supporting a number of prominent medical investigators. Because of the department of medicine's strong tradition of providing the best in clinical care, emphasis will be placed on research that has direct, clinical relevance. As a first step in this process, new laboratories for infectious disease research are being completed. When fully operational, early in 1982, these laboratories will provide facilities for research into the mechanisms by which disease-causing bacteria become resistant to antibiotics. This research, as well as studies designed to elucidate the mechanisms by which antibiotics kill bacteria, will supply us with information which is important for the development of new antibiotics to treat resistant infections. Moreover, facilities will be available in which to develop new methods to diagnose and treat a number of illnesses caused by viruses that presently resist all forms of therapy.

It is clear, as one observes the expertise of the current members of the department of medicine, and as one surveys the broad scope of activities carried out in the department, that Dr. Tullis truly has been a master builder in his 17 years at the helm of the department. The challenge for our future will be to assure the orderly growth of a variety of new programs while, at the same time, maintaining a very clear sight on the central purpose of the department of medicine: to provide the best possible medical care for patients of the Deaconess Hospital. In so doing, it clearly will be possible to insure that the Deaconess remains a warm, caring hospital in which the patient always comes first.

Robert C. Moellering, Jr., M.D.
Chairman

Department of Diagnostic Radiology

"The department of diagnostic radiology remains at the forefront of developing technologies and pursuing clinical research consistent with delivery of the best possible patient care."

The number of studies performed in the Deaconess Department of Diagnostic Radiology during fiscal year 1981 exceeded original predictions, which were conservative estimates based on the anticipated impact of the Lahey Clinic's move out of Boston to the suburbs. Rather than a 15% drop in volume, the total radiographic volume was 55,993, less than 400 below last year's volume of 56,351. This maintenance of volume reflects vigorous efforts to establish referral agreements with area hospitals, and the establishment of several new services which have experienced a rapid rise to near capacity utilization. Further, the Lahey patients often had undergone their diagnostic workup before admission to the Deaconess. In contrast, Deaconess patients admitted directly during the past year usually have required a thorough diagnostic workup, including all imaging studies.

The department continues to change and evolve with the introduction of newer, noninvasive imaging modalities, such as those used in our sections of computed tomography, ultrasound, and nuclear medicine, as well as in our noninvasive vascular laboratory, established last year. The number of invasive diagnostic studies performed primarily by angiography has diminished, while the number of therapeutic nonsurgical procedures using angiography has continued to increase. Examples of these therapeutic techniques are: transluminal angioplasty (dilation or widening of obstructed and narrowed arteries by balloon catheters); hepatic artery embolization (disabling a liver tumor by cutting off its blood supply); infusion chemotherapy of liver tumors.

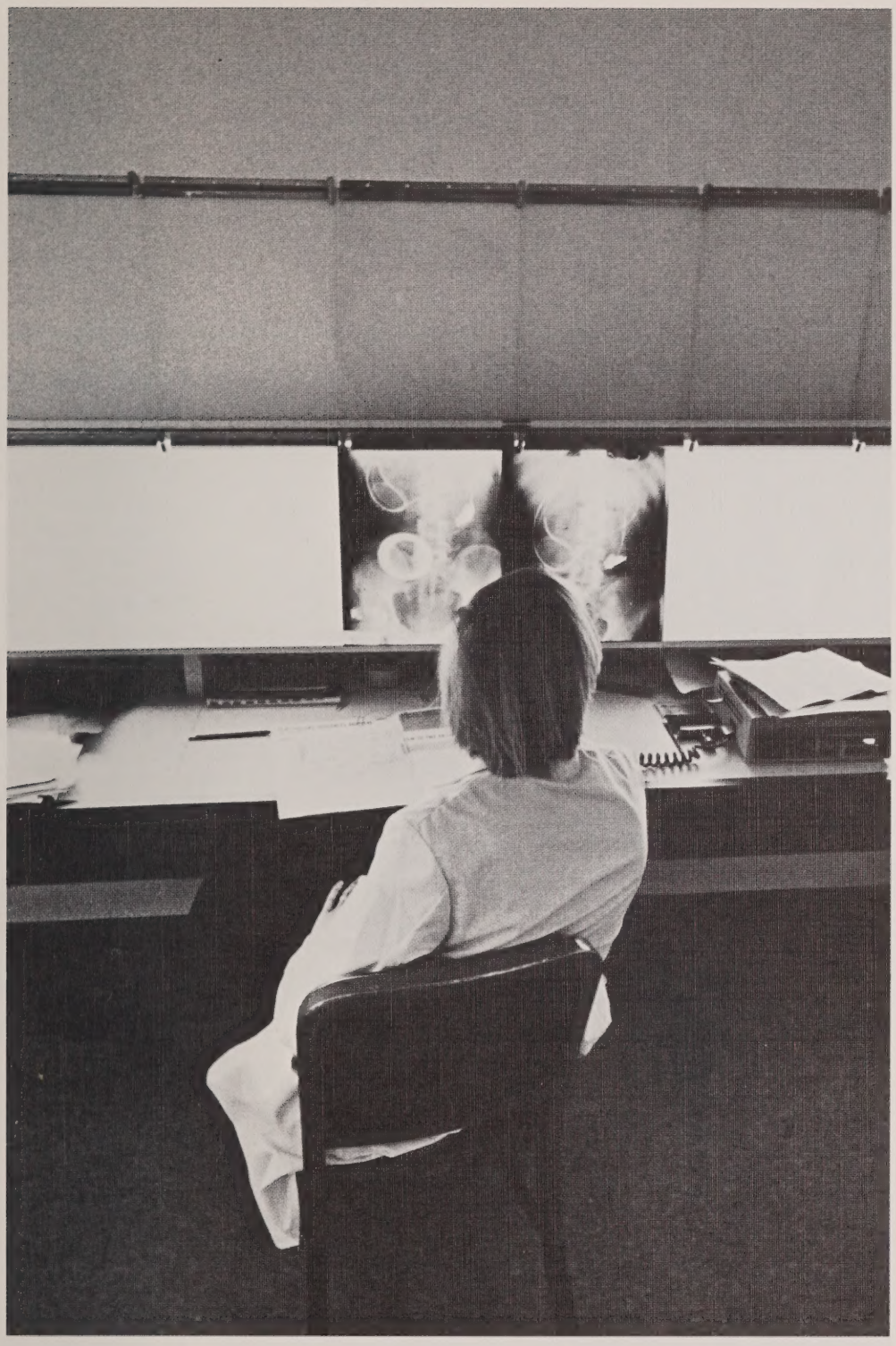
The hospital's new computed tomographic unit (CT scanner), installed in late 1980, offers rapid scanning for anatomic detail of the head and body. This widely publicized technique provides maximum clinical information while remaining noninvasive. The applications for computer tomography continue to expand. The Deaconess CT unit examined 4,500 patients this year, an enthusiastic response well above the 2,500 studies predicted for its first year of operation.

The emission computed tomographic unit (ECT) at the Deaconess is one of three units in the United States used initially to detect brain masses by means of isotopes that localize in tumor tissue. The unit is now being used to assess brain physiology with a new isotope (IMP) that reveals cerebral blood flow and metabolic functioning. With IMP, changes in brain physiology immediately after a stroke are visible before the anatomic changes detectable by x-ray computed tomography have occurred. The ECT unit also provides a guide to the effectiveness of anticonvulsant therapy, and reveals the increased blood flow after carotid endarterectomy (cerebral artery bypass surgery). The new isotope will allow studies of this sort to be done in every major medical center in the country, obviating the need for PETT (positron emission transaxial tomography) and at a fraction of its cost. PETT can be done only in a few research centers with a cyclotron (nuclear reactor) to produce short-lived, positron-emitting isotopes.

In our noninvasive laboratory, a new Diasonics real-time ultrasound unit offers diagnosis of carotid or superficial temporal atherosclerosis (abnormal thickening and hardening of artery walls) by producing longitudinal or cross-sectional images of the carotid artery. These images are combined with a Doppler probe which measures the blood flow across an abnormally narrow area. Our assessment of the ability of noninvasive ultrasound equipment to diagnose vascular disease is part of a five-institution study of the technique, the utility of the instrumentations and the indications for the procedure. With grant funding from the federal government, the department is evaluating this new procedure while assuring that Deaconess patients benefit directly from its capabilities.

The department has begun renovations for a new angiographic and special procedures suite to be equipped with instruments which minimize patient radiation exposure while providing maximum clinical information. This unit will share the services of a digital radiographic unit that has been requested as part of our Determination of Need application for a new radiographic fluoroscopic room. Our referral arrangements help to assure that these new units will receive full utilization and, therefore, justify the costly, but clinically necessary, investment.

As a clinical discipline, the field of diagnostic radiology also is changing as the equipment for imaging procedures achieves greater capability combined with more patient comfort. Clinical research is an integral requirement for quality care in this dynamic atmosphere. At the Deaconess, our new subsection of clinical research aids in the analysis of new equipment to identify those patients who truly can benefit the most.



An example of the potential for innovation in diagnostic radiology is the development and application of interventional therapeutic procedures made easier by diagnostic imaging. These procedures include hepatic artery infusion chemotherapy, embolization and transluminal angioplasty.

Many patients who do not respond to intravenous infusion of the chemotherapeutic agent will respond to chemotherapy delivered selectively through a catheter placed in the hepatic (liver) artery. Since 1972, a team of Deaconess radiologists, oncologists and surgeons has contributed to the design and treatment of these techniques now being used more widely throughout the United States. An extension of this technique is embolization (blockage) of primary and metastatic tumors through the same arterial catheter using very fine particles to cut off the blood supply to tumors without destroying normal liver tissue.

Transluminal angioplasty involves the dilatation or widening of partially closed arteries by passing a larger catheter through the obstruction, or by inflating a balloon catheter placed in the artery under fluoroscopic (x-ray) guidance. After the artery is enlarged, the balloon catheter is deflated and removed, leaving the intraluminal diameter of the artery large enough to allow unobstructed blood flow to the peripheral limb or organ. Long-term results from Europe and other centers in the United States indicate that arteries remain unobstructed for a period of time equal to that achieved through bypass surgery. This technique works best when applied to patients with short segments of arterial disease, or segments that are not completely unobstructed. Patients with complete obstruction or long segmental disease continue to benefit most from surgical treatment.

The department of diagnostic radiology remains at the forefront of developing technologies and pursuing clinical research consistent with the delivery of the best possible patient care. We will continue to use our available resources for these efforts. In our view, it is part of the Deaconess tradition of always putting the patient first.

Melvin E. Clouse, M.D.
Chairman

Department of Pathology

"The Deaconess Department of Pathology always has considered quality patient care as being the first among three hallmarks of good medicine — followed by education and research."

The Deaconess Department of Pathology always has considered quality patient care as being the first among three hallmarks of good medicine — followed by education and research. Although it is not always possible to separate these components, it is the placing of individual patients and their well-being above all else that traditionally has been, and remains, the distinguishing feature of the Deaconess.

In the department of pathology, this means that our staff must continue to provide a very diverse panel of clinical laboratory tests, while keeping abreast of new tests that are developed and contributing to that development. Since quality control is essential in all laboratory measurements, a great effort is required by our staff, each time a new procedure becomes available, to assure its clinical significance and validity as well as to determine whether or not accurate results can be achieved in the laboratory setting.

A major achievement in our response to critical clinical needs has been the establishment of a "stat" (*statim* or immediate) laboratory in the operating rooms as an extension of our main laboratories in the Meissner Building. With 600 stat procedures being performed each day, it was clear to us that there are multiple levels of immediacy in the procedures requested, and that the tests really requiring instantaneous answers were being buried. As a result, our clinical pathologists devised a new system of blood drawing to achieve more rapid answers to test requests. The stat laboratory then handles the true emergency tests. These initial steps have been fruitful, and we expect to refine the system even further when a new, completely equipped stat laboratory is

opened later this year on the sixth floor of the Farr Building, our central patient care facility.

The first steps we have taken toward establishment of an inclusive computerization system for pathology illustrate some of the problems of shifting to computers. Although the end result should be more rapid and accurate reporting of test results to patient floors, the change to inclusive computerization slowed our response for a short time. The addition of faster analyzing equipment in our chemistry laboratories has assisted in the effort to constantly speed up this process.

When one considers the swift advances in clinical laboratory test procedures over the past few years, it is clear that the well-equipped laboratory of the present day is entirely different from that which existed just ten years ago. Some laboratory procedures now provide answers in hours instead of the one to three days required in some instances earlier. Such increased laboratory capacity has special significance in today's medical care setting, particularly in relation to the administration of therapeutic drugs. Since an adequate level is essential for successful therapy, but a level high enough to be toxic obviously has to be avoided, the rapidly developing and progressing ability to measure actual circulating levels of therapeutic drugs in a patient's blood has resulted in much better control of potent drug utilization.

The cooperative efforts of our pathology department with other institutions allow for a more sophisticated and efficient laboratory system and better service to our patients. Those efforts involve collaboration with the New England Baptist Hospital, the Lahey Clinic Medical Center, the Massachusetts Mental Health Center and, a recent addition, the McLean Hospital. Just as important is the cooperation and support of our own Deaconess Hospital community, as exemplified by the 400 one-gallon blood donors who demonstrate their concern for others through participation in the hospital's blood donor program.

The hospital's teaching and research programs, including those in our pathology department, supplement patient care services by helping to produce highly trained and motivated individuals as well as new knowledge that can be applied in the delivery of quality health care.

An additional supportive force is the administrative staff that helps to facilitate the department's operations. The creation of a new position, administrative pathologist, has been an important, positive step in the management of our pathology department. First to hold this position was Dr. Elgin C. Cowart, Jr. who developed the concept of the position following his retirement as director of the Armed Forces Institute of Pathology.

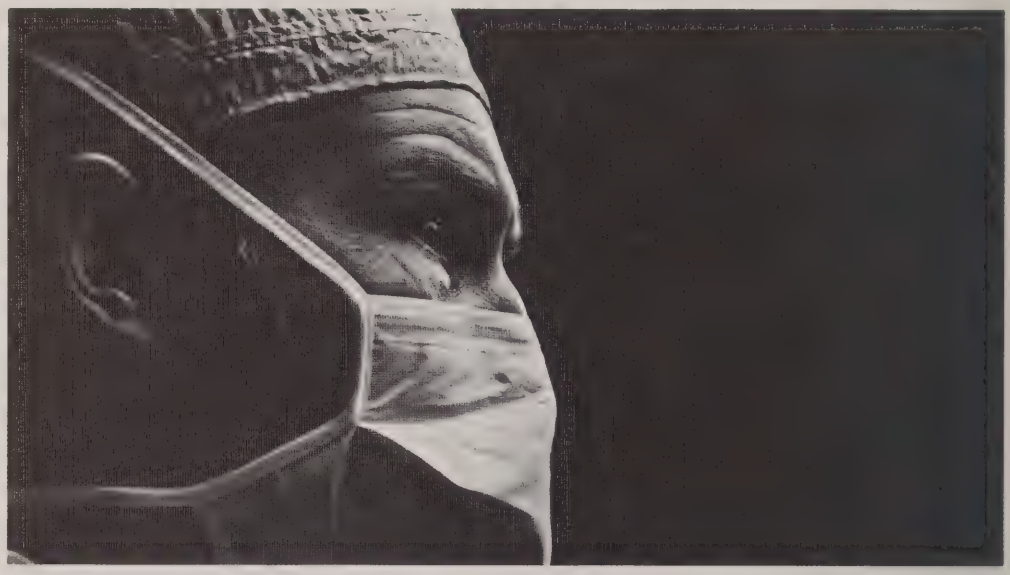
The addition of several new staff members in the pathology department has significantly expanded our capabilities. Dr. Barbara W. Zaias joined us in neuropathology, and Dr. Saad J. Ghosn in clinical chemistry. Dr. Zaias replaced Dr. E. Tessa Hedley-Whyte who moved to the Massachusetts General Hospital after several years of service and important contributions at the Deaconess.

Merle A. Legg, M.D.
Chairman

Department of Surgery

"Long distinguished as a center for specialized surgery, the Deaconess continues today to be at the forefront of innovation and leadership in providing surgical services of the highest calibre."

Long distinguished as a center for specialized surgery, the Deaconess continues today to be at the forefront of innovation and leadership in providing surgical services of the highest calibre. Consistent with the hospital's tradition of putting the individual patient and his well-being ahead of all other concerns, the Deaconess Department of Surgery strives to provide every patient with the highest level of expertise and compassionate care while introducing the most advanced and innovative surgical technology. The enthusiasm, knowledge and concern of the department's physicians and staff are unchanging attributes which permit the integration of the complex technology which is a characteristic component of surgical care practiced today.



Technological advancements of previous years have become part of routine procedure, and newer approaches to disease are introduced constantly. The use of laser instruments has added a new dimension to gynecologic and general surgery operations. We also have increased our experience with the ultrasonic scalpel to enhance the safety of certain procedures within the abdominal and cranial cavities. Another example of the application of industrial technology within the surgical setting is the expanding use of image-intensifier x-ray cameras and screens to provide instantaneous monitoring of certain orthopedic (involving bone structure) and endoscopic (using an instrument for visualizing the interior of a hollow organ) operations.

Extensive renovations of the hospital's operating suites have been completed, including improved lighting, noise abatement and increased electrical capacity. In addition, certain areas have been furnished with instruments, microscopes and ancillary equipment required for various specialized surgical activities. One of the most promising developments in multidisciplinary oncology (cancer care) is the potential role for intraoperative radiation. The Deaconess has moved to the forefront of this capability by being the first hospital in the country to install a dedicated radiotherapeutic unit within a specially designated operating room.

To better serve the surgical staff and their patients, the department of surgery, in cooperation with the department of ambulatory services, has established a surgicenter program for "ambulatory" patients having surgery under anesthesia. This increasingly popular concept allows a patient to come to the hospital shortly before the scheduled hour for certain planned operations, have any required tests performed, and then be accompanied directly to a designated operating room. Following completion of the brief operation, a specially trained, professional team administers postoperative care which enables the patient to return home within two to four hours after surgery. Enthusiastic patient and surgeon acceptance of this new concept is certain to lead to further development of this more cost-effective and less anxiety-producing approach to surgical care.

Growth has continued in various divisions of the department. Orthopedic surgery, under the direction of Dr. William R. MacAusland, Jr., has moved into the area of major joint reconstruction in the care of complex orthopedic problems. Under the leadership of Dr. Daniel Miller, the Deaconess Division of Otolaryngology has developed rapidly, particularly with respect to multidisciplinary oncologic problems involving the head and neck region. There also has been a steady increase in the operative and patient care activities in cardiothoracic (heart and lung) surgery. Dr. F. Henry Ellis, Jr., of the Lahey Clinic Medical Center, head of the Deaconess Division of Thoracic and Cardiovascular Surgery, will continue in this role. Our efforts in oncology have been strengthened by the recent return of Dr. Blake Cady as coordinator of surgical oncology.

Vigorous research activities continue within the Cancer Research Institute. Dr. Anthony P. Monaco serves as scientific director of the institute while also heading the division of transplantation and immunology. This

unit continues to implement new developments in the field so as to benefit complex patient care problems. In the area of nutrition and metabolism, Dr. George L. Blackburn and Dr. Bruce R. Bistrian continue their national leadership roles by integrating metabolic research activities with the most sophisticated of patient support techniques. A new division of critical care also has been established under the direction of Dr. Blackburn.

The entire Deaconess Hospital community shared the loss created by the death of Dr. Elias Menkes, former codirector of the intensive care unit. Dr. Peter N. Benotti recently joined the unit as associate director to integrate delivery of critical care in these areas, and further developments in cooperation with the department of medicine are under discussion.

The department of surgery continues its commitment to surgical education at many levels as an important component of optimal patient care. Educational programs are provided both at the Deaconess and at neighboring institutions to help the practicing surgeon keep abreast of the latest developments and to encourage within the larger medical community an appreciation of the unique capabilities available within our department of surgery. The Deaconess-Harvard Surgical Residency Training Program continues to be an integral element of the department's responsibilities and priorities.

In summary, the Deaconess Department of Surgery will continue to extend every effort in the development and expansion of the hospital's reputation for excellent patient care and in encouraging and supporting its three-fold mission — as a tertiary care referral hospital, as a strong component of the educational program of the Harvard Medical School, and as an academic center pioneering in clinical and basic research activities.

William V. McDermott, Jr., M.D.
Chairman

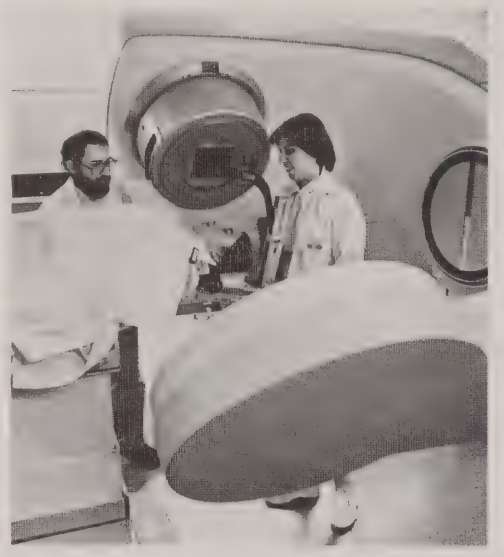
Joint Center for Radiation Therapy

"... patient care, education and a multifaceted research program continue to be the major activities of the Joint Center for Radiation Therapy and its Deaconess division."

During its 13th year, the Joint Center for Radiation Therapy (JCRT) received 2,604 new patients from its member hospitals in the Longwood medical area. This represents a 4.4% increase in new patients over the last year. Nearly a third of these new patients were from the Deaconess Hospital. As a result, the center continues to operate at or over capacity, with machines and staff working extended hours, creating serious problems in scheduling, patient delay and equipment failure. This situation will be alleviated somewhat with a variety of planned changes in the physical plant. However, the basic problem will persist until increased capacity can be developed with the purchase of additional linear accelerators to be installed at other JCRT member hospitals.

An orthovoltage radiation therapy machine has been placed into a specially designed operating room at the Deaconess. This installation — the first such dedicated unit in the country — will allow radiation therapy to be used on selected deep-seated tumors during surgery. Abdominal tumors are difficult to control because of the extreme sensitivity of surrounding organs and structures. Using intraoperative radiotherapy, certain organs can be pushed aside so that little normal tissue is exposed to radiation while the tumor receives an optimal dose. This procedure offers the promise of increasing cure rates for patients with deep-seated tumors.

The new, combined treatment planning department at Sidney Farber Cancer Institute is operating well, with central computer facilities which allow access to all JCRT-affiliated hospital departments. These serve recordkeeping, library, data retrieval, radiation safety, machine calibration, special patient studies and accounting needs. The main function of these computer facilities, however, is to



provide treatment planning support for the entire JCRT, including the separate computer-controlled radiation therapy project at the Deaconess. Most interestingly, the new Farber Institute computer facility will allow graphic display of both treatment plans and computerized axial tomography (CAT) scans through terminals located in all JCRT institutions. This electronic access to the treatment simulation and planning unit, combined with computerized control of radiation dose at the Deaconess, greatly improves communication between physicians and technicians and enhances the quality and delivery of patient care.

Throughout all JCRT clinical projects, there has been concern with multimodality therapy. This involves combining radiation, surgical and chemotherapy treatments with the ultimate goal of reducing their side-effects while increasing the prospects for cure. This approach has been successful in treating pediatric tumors, breast cancer and lymphoma, and now seems to be effective in studies of head and neck cancer done in collaboration with the Farber Institute. These studies appear to show an increase in tumor control and survival using such multimodality therapy.

The JCRT's physics research has been focused on the dose optimization project. This project relies upon the Deaconess Hospital's computer-controlled radiation therapy service which attempts to maximize the dose delivered to a patient's tumor while minimizing the effects upon normal tissue. Continued physics research into the distribution of dose outside the primary beam of radiation (scatter) is important for safety as well as for minimizing dosage to normal tissue.

A great loss was felt at the center with the death of its deputy director, Dr. Martin B. Levene, following a long illness. Martin will be missed by all of us. With his death, the center has been reorganized administratively. In place of a deputy director, there are four associate directors: Dr. James A. Belli, associate director for biology; Bengt Bjarngard, associate director for physics; Dr. Jay R. Harris, associate director for clinical activities; Richard Roberts, associate director for administration.

Our best wishes go to Dr. Arnold W. Malcolm who has left JCRT to accept the chairmanship of a new department of radiation therapy at Vanderbilt University. Dr. Tyvin A. Rich has moved from Beth Israel Hospital's radiation therapy department to replace Dr. Malcolm at the Deaconess.

In summary, patient care, education and a multifaceted research program continue to be the major activities of the Joint Center for Radiation Therapy and its Deaconess division. While these studies proceed at many levels, they all have as their goal, a reduction of the morbidity and mortality associated with malignant disease, as well as improvement of the quality of life for all our patients.

Samuel Hellman, M.D.
Director

Shields Warren Radiation Laboratory

"Although major emphasis is placed on cancer and cardiovascular disease, the work of the laboratory also has important applications in general medical practice."

Named for the late Dr. Shields Warren, the renowned radiological research pioneer who made so special a contribution to the life of the Deaconess, the Shields Warren Radiation Laboratory is a unique center devoted to investigation and teaching in the radiological sciences. Its broadly based programs are concerned with the use of ionizing radiations in medical diagnosis and treatment and with their potential hazards in industry. Although major emphasis is placed on cancer and cardiovascular disease, the work of the laboratory also has important applications in general medical practice.

This year has seen the retirement of Dr. Henry I. Kohn, who served as scientific director of the laboratory from its opening, until over a year ago, and who continued his research in radiation biology until this year. His presence will be missed.

Research support through the Harvard Medical School has continued to be strong, and considering the nature of the research done in the facility, it probably will continue to be in the future.

Experimental Radiology

Under the leadership of Dr. Herbert L. Abrams, investigational work in the radiological sciences covers a broad range, with a major focus on neoplastic disease. In this area, new agents have been identified for imaging primary and secondary cancer in the liver by computerized axial tomography (CAT scan), as have factors involved in the recruitment of a new blood supply by tumors, a crucial step which permits growth of a cancer beyond a few cells. Methods also have been developed to enhance the identification of cancer by pharmacoangiography (use of drugs to produce x-ray images of blood vessels), the characteristics of lymph nodes in response to immune mechanisms and cancer metastasis, and the immunologic factors in the regression of a cancer model having identical genes.

The humoral factors responsible for the recruitment of a collateral blood supply to the heart and kidneys, following obstruction of a major artery, also are being explored. A factor toxic to normal myocardium (muscular wall of the heart) in lymph draining ischemic myocardium has been identified. The laboratory also is investigating the characteristics of the coronary, renal, and central nervous system blood supply in a number of settings: the role of the renin-angiotensin-aldosterone system in the pathophysiology of hypertension and congestive heart failure; the use of gated computerized axial tomography and single photon emission tomography for assessing ischemic myocardium. The disordered heart muscle metabolism in the myocardopathy induced by the widely employed cancer treatment agent, adriamycin, also is being explored.

Experimental Nuclear Medicine

Under the direction of Dr. S. J. Adelstein, this group devotes its work to basic radiobiologic studies, to the development of new radiopharmaceuticals and to a better understanding of radionuclide toxicity.

Efforts in basic radiobiology have focused on the effects of radiation on chromatin, the basic genetic material of mammalian cells. Recent research has demonstrated that radiation produces profound changes in this material, including fragmentation and cross-linking of chemical compounds in ways that must interfere with their function.

In a collaborative effort with the chemistry department at Massachusetts Institute of Technology, the basic chemistry of the element technetium is being unraveled. The radioelement technetium-99m is the most commonly used radionuclide for diagnostic nuclear medicine. The design of new, effective diagnostic agents will depend upon increased knowledge of its chemistry.

Public and professional concern about radioactivity lies behind the group's efforts to delineate the toxic effects of these materials at microscopic levels. This understanding has led to the development of an effective therapeutic agent, as well as a better definition of the hazards and safety of some materials at low levels.

Robert D. Pence
Administrative Director

Cancer Research Institute

"The Cancer Research Institute's activities continue to expand as investigation uncovers comparisons between animal response to disease with that experienced in humans."

The Cancer Research Institute's activities continue to expand as investigation uncovers comparisons between animal response to disease with that experienced in humans. Basic understanding of disease origin and development gained from animal research eventually can be applied to diagnosis and treatment of disease in human beings.

To meet new research project needs, three shell floors of the institute's new wing currently are being completed for occupancy by the transplantation and immunology division and the Deaconess Department of Medicine. Over the next few years, a major institute goal will be to obtain funding from industries and foundations and to attract personal grants and gifts. Such support is imperative since federal funding of new research projects is becoming increasingly limited.

Biochemistry
Under the leadership of Dr. W. Eugene Knox, the institute's biochemistry laboratory has discovered a mutant gene in research rats. Hereditary abnormalities among experimental animals are a valuable source of disease models for comparison with human varieties and for extending basic understanding of bodily functions by finding out what can go wrong. The latter function was a consequence of identifying *infantile ichthyosis* in rats, a benign condition manifesting itself before the rat pups have developed hair, when an excess of skin cells accumulates and large sheets or entire casts of the superficial skin layers are shed. Studying a new strain which affects all animals has shown that the condition is limited to the early period of life and is qualitatively different from familiar forms of hyperkeratoses (excessive skin development) such as psoriasis.

The existence of an "i" gene called attention to a previously unknown stage in skin development. The new abnormality shows an earlier, independent stage consisting of the first development of a multilayered system. This first development is excessive in ichthyosis, but in later stages, the classical differentiation of skin cells occurs continuously and normally.

Experimental Pathology
Led by Dr. Clark E. Brown, three main lines of cancer research have been pursued: a general summary of the tumors resulting from a single, massive whole-body dose of x-ray administered to parabiosed rats, initiated by Dr. Shields Warren 26 years ago, is being completed; interstitial tumors of the rat testis have been produced by high levels of gonadotropic hormones generated internally by surgically uniting a castrate with a normal rat; the suppressive effect of hypophysectomy on the spontaneous incidence of pheochromocytoma (an adrenal tumor associated with hypertension) has been demonstrated in the laboratory's rat colony. Investigation of this tumor is continuing with Dr. William M. Manger of the National Hypertension Association.

Mammalian Differentiation
Disposal of ammonia is a critical metabolic function of mammalian liver. Adult liver is the only tissue containing the complete enzymatic equipment for ammonia detoxification via the urea cycle. Fetal, neonatal, and neoplastic liver lack some enzymes regulating the urea cycle in the adult. Under Dr. Annemarie Herzfeld, this research group has been studying physiological factors that trigger the appearance of these enzymes during development, and is investigating biochemical events controlling it in the normal and abnormal rat. A partial urea cycle also can be detected in a few extrahepatic tissues. The distribution and properties of the enzyme comprising it are being analyzed to determine if alternate organs can take over this vital hepatic function.

Medical Oncology
With assistance from the hospital's surgery and radiation therapy departments, investigation is proceeding into the use of hyperthermia on tumors of the lung, liver and pancreas, as well as superficial tumors. Hyperthermia involves the raising of body temperature in order to destroy the heat-sensitive tumor cells.

The use of an ambulatory infusion pump technique for continuous delivery of chemotherapy drugs has been expanded. New studies in over 4,000 patient/ observation days indicate virtual elimination of toxic side-effects in the patient and improving cytotoxic effects on tumors.

Under the direction of its chief, Dr. Jacob J. Lokich, the Deaconess Medical Oncology Section is collaborating in cancer trials with hospitals in New Bedford, Massachusetts, and Portsmouth and Dover, New Hampshire.

Treatment of oat-cell carcinoma of the lung and other forms of bronchogenic carcinoma and non-Hodgkins lymphomas has been initiated. Collaborative adjuvant therapy of colon and breast cancer has been started, the latter as part of the National Surgical Adjuvant Breast Project. Studies of tumor markers continue, based on a serum bank of specimens from over 4,000 patients.

Nutrition
The goal of this research, directed by Dr. George L. Blackburn, is to maintain the body's host defense mechanism which is responsible for preventing or contracting infection or cancer and for the promotion of wound healing.

The laboratory's computer science section is identifying the role of diet and nutritional status in the treatment of

hospitalized patients, and it has been learned that tests of serum protein can predict risk of illness to create morbidity and mortality.

In the animal laboratory, a mediator of metabolic response to injury and illness has been identified. Its impact on survival appears similar in all types of stress, and provides a unique, specific method to test nutrition therapies optimal for treatment of various illnesses.

Surgical Metabolism

Under the supervision of Dr. George H. A. Clowes, Jr., research is being directed toward greater understanding of how energy production and protein synthesis are affected by the presence of severe infection, cancer, or serious injury. Studies have demonstrated a significant increase in the release from muscles of amino acids which are taken up at a high rate by the liver and other central tissues where they are used for synthesis of proteins essential to maintain immunocompetence, wound healing, and recovery. From blood plasma, a potent glycopeptide inducing muscle protein breakdown has been isolated in a nearly pure form. No known hormones have been found to have this effect. At the same time, clinical measurements of the augmented clearance rate of amino acids by the liver correlated well with amino acid oxidation and protein synthesis in incubated liver slices. This demonstrates a valuable means of assessing liver function in patients with cirrhosis and other forms of hepatic insufficiency. These results are being employed to develop new therapeutic methods for improving surgical outcome in this group of complicated illnesses.

Transplantation and Immunology

Dr. Anthony P. Monaco has directed experiments designed to determine how blood transfusions to prospective kidney transplant recipients can augment transplant survival. Studies show that the effectiveness of pretransplant blood transfusion is, in part, related to the genetic differences between donor and recipient. When these differences are large, transfusions must be performed using specific blood from the donor to increase organ graft survival. With weaker genetic differences, third-party blood transfusions achieve a salutory effect. When transfusions augment graft survival, one immunological mechanism involved is the induction of T suppressor cells which prevents graft rejection. It has been shown previously in this laboratory that bone marrow can augment graft survival in immunosuppressed recipient animals. It now appears that augmented survival also is achieved by the induction of suppressor cells. A project is underway to study human bone marrow to determine the cellular factors responsible for the induction of suppressor cells when marrow is administered to immunosuppressed recipients in achieving prolonged graft survival.

Studies continue on the isolation of tumor-associated antigens in bladder neoplasia. This laboratory and others have found that most antigens are nonspecific rather than specific for individual tumor. Nevertheless, it is likely that utilization of one, two, or three nonspecific antigens in series will permit evaluation of the presence and total amount of tumor burden in patients. Analysis of tumor-associated antigens eventually will be used to monitor administration of antitumor therapy.

Research Administration

Under the supervision of Robert D. Pence, the research administration department serves the entire Deaconess Hospital. Whereas, in the past, its work has been almost totally dedicated to the institute, currently increasing hospital-wide interest in research is resulting in a broadened role for research administration in the preparation, submission, and management of research grants and contracts for other Deaconess departments.

The office of grants and contracts, overseen by Mark A. Flaim, has experienced a resurgence of activity, processing some 16 new and competing grant applications in addition to 10 continuation applications yearly. The office continued to manage the hospital's 20 active grants and contracts, and also has been involved in overseeing the completion and outfitting of the research laboratories in the institute's new wing.

Managed by Candice Fullwood, the protocol and cancer administration office has added management of the radiation safety and radioactive drug research committees to its responsibilities for the clinical investigation and cancer committees. Over 75 new clinical research protocols were processed for approval, and a major revision of the hospital's policy on human subjects research is underway. Under the direction of Dr. Jacob J. Lokich, enrollment and randomization of women on the National Surgical Adjuvant Breast Protocol was assumed. In addition to the weekly tumor board and tumor conference, the office also coordinates Dr. Albert L. Sheffer's postgraduate course in allergy and immunology and the spring cancer symposium.

Anthony P. Monaco, M.D.
Scientific Director

The New England Deaconess Hospital: A Tradition of Caring and Leadership

"Throughout almost a hundred years, one characteristic of the Deaconess has remained unchanged: the recognition and affirmation of the individual patient and his well-being as the hospital's *first priority*."

The Deaconess is a special place — a unique health care institution. For nearly a century, it has been a pioneer and leader in the development and delivery of innovative, patient-centered medicine, with particular emphasis on the individual and his needs as a total person.

Founded in 1896, the Deaconess takes its name from the eight deaconesses of the Methodist Church who established it as a 14-bed, home-hospital dedicated to serving the health care needs of the Boston community. The Deaconess was imbued with its initial spirit by those eight compassionate laywomen who established it to meet pressing human needs. Just as important is the legacy it received from them — a legacy of devotion to patient care of the highest quality.

Today, the Deaconess is a private, nonsectarian specialty-referral hospital, sophisticated and innovative in its approach to modern medicine, but still dedicated to the best possible patient care. With its staff of over 2,500 and its 489-bed, 14-building complex located in the famed Longwood medical area, the Deaconess continues to serve the medical and surgical needs of its general staff as well as patients of the Joslin Diabetes Center and the Overholt Thoracic and Lahey Clinics with which it is associated. A teaching affiliate of Harvard Medical School, the Deaconess has trained hundreds of young physicians, surgeons and medical technicians who are now in practice throughout the world. In keeping with its tradition of caring and leadership, the Deaconess combines quality patient service with exceptional clinical care and research aimed at direct benefit to patients everywhere.

Medical research is conducted by the hospital's Shields Warren Radiation Laboratory and its Cancer Research Institute, as well as by individual departments and members of the Deaconess staff in a number of specialized areas. Many of the developments resulting from this research have influenced the practice of medicine in this country and around the world.

From modest beginnings, serving the people of Boston, the Deaconess has grown and matured into a major teaching hospital, staffed by outstanding medical professionals, equipped in every way to meet today's demand for widely varied medical and surgical services. It is particularly distinguished for its work in chest surgery, and for diagnosis, treatment and research in cancer, diabetes, cardiac and renal disease and their related complications, as well as in general medicine.

Throughout almost a hundred years, one characteristic of the Deaconess has remained unchanged: the recognition and affirmation of the individual patient and his well-being as the hospital's *first priority.*

A Profile of the Hospital

Annual Statistics (Fiscal Year 1981)

Number of beds	489
Admissions	12,581
Average length of stay	12.0 days
Patient meals	444,618
Surgical procedures	6,005
X-ray examinations	56,712
Radiation therapy treatments	16,172
Laboratory tests	28,122,761
Outpatient visits	50,700

The Deaconess Family

Medical Staff	446
Honorary Staff	29
Basic Research Scientists	18
Residents (medical & surgical)	119
Trustees	25
Corporation Members	178
Employees	2,596
School of Nursing enrollment	188
Friends of the Deaconess (including 75 life members)	456

Finances (Fiscal Year 1981)

Total operating revenue	$82,888,693
Total expenses	$82,946,426
Loss from operations	$ 57,733
Nonoperating revenue	$ 2,324,047
Net income	$ 2,266,314

Facilities

Diabetes Treatment Unit
Observation Unit (emergency by car or private ambulance only)
Ambulatory Care Unit (surgical and diagnostic day care)
Cancer Research Institute
Shields Warren Radiation Laboratory
Meissner Laboratory
Lowry Medical Office Building
School of Nursing (3-year diploma school)

Friends of the Deaconess

"They help to create the atmosphere of warmth and compassion for which the Deaconess is so widely known."

The Friends of the Deaconess have made an important, generous contribution to the hospital's growth and progress for half a century. In 1931, they recognized that the Deaconess was a special place when the founding members first met to provide assistance in caring for the hospital's patients. Since then, the Friends have served the Deaconess, its patients and the larger, external community in countless undertakings — from the preparation of surgical dressings, to the performance of vital emergency functions as Red Cross Gray Ladies during World War II.

Today, the Friends operate the Deaconess Gift and Thrift shops, with all proceeds going to support the hospital. In addition, they sponsor annual events such as the Christmas Bazaar and Night at Pops, and contribute generously to the New England Deaconess Hospital School of Nursing Scholarship Fund. Over the past 50 years, the Friends have given more than $1 million to the hospital for new equipment and renovations.

But beyond financial support, the Friends carry on their tradition of initiating programs and activities which provide a pleasant respite from daily hospital routine for our patients and their families as well as our staff. An annual Christmas open house, the recently dedicated rooftop garden on the Baker Building, holiday decorations for patients meal trays — all important amenities which contribute immeasurably to easing the anxiety level of patients and their loved ones, while enabling busy staff members to relax a bit from the steady, bustling pace of a major medical center.

These varied expressions of concern and support are the continuous gift of the Friends of the Deaconess. They help to create the atmosphere of warmth and compassion for which the Deaconess is so widely known.

Mrs. Lois J. Krall, President
Friends of the Deaconess, Inc.

Department of Volunteer Services

The Deaconess — a special place served by a very special group of people. More than 150 in number, they generously contribute their time and effort in 30 different areas of the hospital. They are Deaconess volunteers, enthusiastic and devoted men and women, age 15 to 80. They can be seen everywhere in the hospital, giving assistance in the main lobby, the messenger service, diversional therapy, the diabetes treatment unit, intravenous and physical therapy and the gift shop.

A new area of responsibility for our volunteers is the patient services department, where they serve coffee, provide a sympathetic ear, and generally assist Deaconess patients at the potentially anxious time of admission to the hospital. This extra measure of care and concern from volunteers is consistent with the Deaconess tradition of putting patients first.

Working through the pastoral care and dietary departments, our volunteers have become an integral part of the oncology cluster unit (OCU), an involvement that reached a high point last April when Mrs. Marion Upton Clouse, volunteer coordinator of OCU support groups, was one of nine greater Boston citizens to receive United Way's prestigious 1980 Voluntary Action Center Award for outstanding volunteer service.

Deaconess volunteers play a unique, caring role in the life of our hospital. In an era of rising hospital costs and shrinking resources, volunteers provide supplemental services and release professional health care personnel from nonprofessional but important duties.

We are very proud of our volunteers and their accomplishments. We look forward to continued growth of our volunteer program and expanded service to all departments of the Deaconess.

Mrs. Phyllis Wasserman
Assistant Director of Volunteer Services

Report of the Treasurer

In the 1980 annual report, I stated that the major challenge for the hospital in 1981 would be to manage successfully the impact of Lahey Clinic's opening of a new hospital in Burlington. The following table of statistics indicates the significant impact of the Lahey transition, especially for those statistics that pertain to our occupancy level:

	1981	1980
Occupancy	85.4%	94.2%
Patient days	152,032	167,633
Average daily census	417.7	460.5
Average stay (days)	12.0	11.5
Surgical procedures	6,005	7,170
X-rays taken	56,712	56,349
Radiation therapy	16,172	17,170
Laboratory units	28,122,761	28,076,319

It is interesting to note the continuing intensity of services rendered by the diagnostic radiology and pathology departments, despite the decrease in occupancy levels. We believe this reflects the fact that we continue to see a large number of patients with complex medical and surgical problems.

The excess of revenues over expenses was $2,266,314 for 1981. This compares to the 1980 gain of $1,730,486. We experienced an operating loss of $57,733 versus a gain of $37,559 a year ago. This indicates the importance of nonoperating revenue to the financial strength of the Deaconess.

It will be a significant challenge in 1982 to accumulate adequate funds for working capital and capital equipment replacement in an increasingly regulated environment. The plans for balanced physician recruitment and cost containment, as detailed in the report of management, are designed to achieve this goal.

James F. Morgan
Treasurer

New England Deaconess Hospital

Financial Statements for the fiscal years ended September 27, 1981 and September 28, 1980, and Auditors' Opinion

Balance Sheets

September 27, 1981 and
September 28, 1980

Assets

Unrestricted Funds		1981	1980
Current Assets:	Cash and invested cash equivalents	$ 128,096	$ 1,160,333
	Current portion of designated assets (Note 2):		
	Trustee designated for equipment and renovations	1,028,000	
	Assets held in trust under long-term debt agreements (Note 4)	475,000	1,200,000
	Accounts receivable — less allowance of $1,916,000 in 1981 and $2,205,000 in 1980 for uncollectible accounts	13,251,662	11,543,537
	Inventories of supplies — at cost	1,134,311	1,102,407
	Prepaid expenses, etc.	588,042	573,136
	Total current assets	16,605,111	15,579,413
Designated Assets (Note 2):	Trustee designated for plant replacement and expansion (Note 1)	7,057,863	5,138,030
	Assets held in trust under long-term debt agreements (Note 4)	1,853,667	2,006,590
	Total designated assets	8,911,530	7,144,620
Total Current and Designated Assets		25,516,641	22,724,033
Property, Plant, and Equipment—	Net (Notes 3 and 4)	36,980,349	36,071,202
	Total	$62,496,990	$58,795,235
Restricted Funds			
Special Purpose Funds:	Cash and invested cash equivalents	$ 488,638	$ 282,199
	Investments (market value: 1981, $480,000; 1980, $451,000) (Note 1)	532,097	451,542
	Grants receivable	1,401,837	1,286,340
	Total Special Purpose Funds	$ 2,422,572	$ 2,020,081
Endowment Funds:	Investments (market value: 1981, $4,788,000; 1980, $5,379,000) (Note 1)	$ 4,939,824	$ 5,163,925
	Real estate, equipment, and furnishings at cost, less accumulated straight-line depreciation: 1981, $2,085,753; 1980, $1,872,191 (Note 5)	4,500,225	3,944,758
	Total Endowment Funds	$ 9,440,049	$ 9,108,683
Plant Replacement and Expansion Funds:	Cash and invested cash equivalents	$ 106,920	
	Building fund pledges receivable	96,320	$ 176,804
	Total Plant Replacement and Expansion Funds	$ 203,240	$ 176,804

See notes to financial statements.

Balance Sheets

September 27, 1981 and
September 28, 1980

Liabilities and Fund Balances

Unrestricted Funds		**1981**	**1980**
Current Liabilities:	Accounts payable and accrued liabilities	$10,013,301	$ 7,166,226
	Accrual for settlements with third-party payors (Note 1)	2,516,001	3,574,902
	Current portion of long-term debt (Note 4)	749,347	726,753
	Deferred nursing school tuition	598,446	520,160
	Advances from third-party payors	464,392	425,091
	Total current liabilities	14,341,487	12,413.132
Deferred Revenue —	Third-party reimbursement (Note 1)	919,600	952,600
Long-Term Debt (Note 4)		12,851,557	13,814,837
Fund Balances		34,384,346	31,614,666
	Total	$62,496,990	$58,795,235
Restricted Funds			
Special Purpose Funds:	Fund balances	$ 2,422,572	$ 2,020,081
	Total Special Purpose Funds	$ 2,422,572	$ 2,020,081
Endowment Funds:	Accounts payable	$ 142,661	$ 157,863
	Mortgage note payable (Note 5)	1,582,513	1,711,727
	Fund balances	7,714,875	7,239,093
	Total Endowment Funds	$ 9,440,049	$ 9,108,683
Plant Replacement and Expansion Funds:	Accounts payable		$ 25,723
	Fund balances	$ 203,240	151,081
	Total Plant Replacement and Expansion Funds	$ 203,240	$ 176,804

See notes to financial statements.

Statements of Revenues and Expenses

For the Fiscal Years Ended
September 27, 1981 and
September 28, 1980

		1981	1980
Patient Service Revenue		$93,434,770	$79,505,751
Less —	Free care, provision for uncollectible accounts, contractual adjustments, etc.	(15,055,425)	(13,381,150)
Net Patient Service Revenue		78,379,345	66,124,601
Other Operating Revenue	(including $1,550,644 in 1981 and $1,542,342 in 1980 transferred from special purpose funds) (Note 1)	4,509,348	4,362,180
	Total operating revenue	82,888,693	70,486,781
Operating Expenses:	Professional care of patients:		
	General	16,041,571	14,326,025
	Special	31,201,030	26,201,676
	Household and property	7,682,449	6,256,664
	Dietary	4,335,209	4,014,591
	General services and administration	10,636,716	9,061,689
	Employee benefits	7,979,524	5,745,477
	Depreciation (Note 3)	2,625,273	2,292,590
	Research, etc.	1,550,644	1,542,342
	Interest	894,010	1,008,168
	Total operating expenses	82,946,426	70,449,222
Gain (loss) from Operations		(57,733)	37,559
Nonoperating Revenue:	Net income from endowment funds	374,407	517,240
	Unrestricted donations and gifts	154,244	158,932
	Interest, etc.	1,672,207	956,731
	Gain on retirement of bonds	123,189	60,024
	Total nonoperating revenue	2,324,047	1,692,927
Excess of Revenues Over Expenses		$ 2,266,314	$ 1,730,486

See notes to financial statements.

Statements of Changes in Fund Balances

For the Fiscal Years Ended
September 27, 1981 and
September 28, 1980

		Unrestricted Funds	Restricted Funds		
			Special Purpose Funds	Endowment Funds	Plant Replacement and Expansion Funds
Balance, September 30, 1979		$28,287,483	$ 2,137,418	$7,001,459	$ 627,029
Increases (Decreases):	Legacies, gifts, etc.	193,328	409,672	42,137	
	Building fund receipts				427,621
	Grants for specified purposes		1,479,149		
	Investment income		63,671		
	Net gain on sales of investment securities		3,756	164,054	
	Excess of revenues over expenses for the year	1,730,486			
	Transfer to other operating revenue		(1,542,342)		
	Total	30,211,297	2,551,324	7,207,650	1,054,650
Interfund Transfers:	Investment in buildings and equipment	1,004,864	(54,509)		(950,355)
	Other (Note 8)	398,505	(476,734)	31,443	46,786
Balance, September 28, 1980		31,614,666	2,020,081	7,239,093	151,081
Increases (Decreases):	Legacies, gifts, etc.	94,255	682,393	181,000	
	Building fund receipts				239,690
	Grants for specified purposes		1,411,691		
	Investment income		52,251		
	Net gain on sales of investment securities		8,380	314,782	
	Excess of revenues over expenses for the year	2,266,314			
	Transfer to other operating revenue		(1,550,644)		
	Total	33,975,235	2,624,152	7,734,875	390,771
Interfund Transfers:	Investment in buildings and equipment	434,111	(221,580)		(212,531)
	Other (Note 8)	(25,000)	20,000	(20,000)	25,000
Balance, September 27, 1981		$34,384,346	$ 2,422,572	$7,714,875	$ 203,240

See notes to financial statements.

Statements of Changes in Financial Position of Unrestricted Funds

For the Fiscal Years Ended
September 27, 1981 and
September 28, 1980

		1981	1980
Funds Provided:	Operations:		
	Gain (loss) from operations	$ (57,733)	$ 37,559
	Add (deduct) items not requiring current use of funds:		
	Depreciation	2,625,273	2,292,590
	Amortization of bond discount	11,068	11,504
	Reduction in deferred revenue	(33,000)	
	Funds provided from operations	2,545,608	2,341,653
	Nonoperating revenue — net	2,324,047	1,692,927
	Total funds provided from operations and nonoperating revenue	4,869,655	4,034,580
	Unrestricted legacies	94,255	193,328
	Transfers from restricted funds — net	409,111	1,403,369
	Proceeds from Series B Revenue Bonds		2,525,000
	Utilization of noncurrent assets held in trust for redemption of bonds	201,811	279,976
	Total funds provided	5,574,832	8,436,253
Funds Applied:	Reduction of long-term debt	974,348	2,997,477
	Net funding of noncurrent assets held in trust	48,888	147,548
	Additions to property, plant, and equipment	3,534,420	4,614,387
	Increase in trustee designated noncurrent assets	1,919,833	2,138,527
	Total funds applied	6,477,489	9,897,939
Decrease in Working Capital		$ 902,657	$1,461,686
Summary of Changes in the Components of Working Capital:	Increase (decrease) in current assets:		
	Cash and invested cash equivalents	$(1,032,237)	$(1,660,813)
	Current portion of designated assets	303,000	750,000
	Accounts receivable — net	1,708,125	1,640,010
	Inventories of supplies	31,904	215,143
	Prepaid expenses, etc.	14,906	24,437
	Total	1,025,698	968,777
	Decrease (increase) in current liabilities:		
	Accounts payable and accrued liabilities	(2,847,075)	(1,544,464)
	Accrual for settlements with third-party payors	1,058,901	(498,243)
	Current portion of long-term debt	(22,594)	(276,753)
	Deferred nursing school tuition	(78,286)	9,179
	Advances from third-party payors	(39,301)	(120,182)
	Total	(1,928,355)	(2,430,463)
Decrease in Working Capital		$ 902,657	$1,461,686

See notes to financial statements.

Notes to Financial Statements

1. Accounting Policies

General

The accompanying balance sheets of the Hospital are presented in two basic fund accountabilities of unrestricted and restricted funds. Assets restricted by donors and by grants for identified purposes are included in restricted funds and are distinguished from assets allocated for specific purposes by action of the Board of Trustees and assets which are legally limited as to use by the Hospital's long-term debt agreements. Such assets are presented as designated assets of the unrestricted fund.

Gifts and grants restricted by outside sources are added to the appropriate restricted funds. Restricted special purpose funds, when expended for current operating purposes, are transferred to unrestricted funds and are reported as other operating revenue.

The Hospital's fiscal year ends on the Sunday nearest September 30. The 1981 and 1980 fiscal years each consisted of 52 weeks.

Investments

Investments are stated at cost or, if received by gift or bequest, at fair market value when received. Substantially all of the Hospital's investments are included in an investment pool which is operated on the "market value" method. Income and realized gains and losses of the pool are allocated to participating funds based on their respective shares of the pool.

Estimated Settlement with Third-Party Payors

Preliminary calculations of final cost reimbursement adjustments relative to third-party contracts with Blue Cross and Medicare are reported in the accompanying balance sheets as a current liability. Cost reports to be filed for the current year, as well as cost reports filed for 1976 through 1980, are subject to final determination by the reimbursement agency under each program. Variances between preliminary calculations, preliminary settlements, and final settlements are included in the statements of revenues and expenses in the year in which the settlements occur.

Reclassifications

Certain 1980 amounts have been reclassified to conform to the 1981 presentation.

Other

Other significant accounting policies are set forth in the financial statements or in the notes which follow.

2. Designated Assets

Designated assets at year end consisted of the following:

	1981	1980
Current portion:		
Cash and invested cash equivalents	$1,062,867	$ 954,335
Investments (market value: 1981, $422,755; 1980, $235,940)	440,133	245,665
Total current portion	$1,503,000	$1,200,000
Noncurrent portion:		
Cash and invested cash equivalents	$4,305,803	$2,508,910
Investments (market value: 1981, $4,317,262; 1980, $4,550,955)	4,605,727	4,635,710
Total noncurrent portion	$8,911,530	$7,144,620

3. Property, Plant, and Equipment

Property, plant, and equipment of unrestricted funds are stated at cost, including capitalized interest where appropriate, less accumulated depreciation and at year end are summarized as follows:

	1981	1980
Land	$ 640,846	$ 640,846
Buildings	21,833,786	21,812,685
Fixed equipment	23,430,241	21,957,039
Major movable equipment	13,948,300	12,457,722
Construction in progress	652,512	73,097
Total	60,505,685	56,941,389
Less accumulated depreciation	23,525,336	20,870,187
Property, plant, and equipment—net	$36,980,349	$36,071,202

Depreciation is computed using the straight-line method over the estimated useful lives of depreciable assets. As to certain depreciable assets acquired before 1971, the Hospital uses accelerated depreciation methods to determine reimbursable costs under a third-party reimbursement agreement. Revenue attributable to the excess of accelerated over straight-line depreciation has been deferred and will be added to income when the depreciation timing differences reverse.

4. Long-Term Debt

In 1973, the Massachusetts Health and Educational Facilities Authority (the Authority) sold $14,900,000 principal amount of revenue bonds, designated New England Deaconess Hospital Issue, Series A, and loaned the proceeds therefrom to the Hospital. With certain exceptions, principally the Medical Office Building and Kennedy Hall, all of the Hospital's land and buildings (including contents) are pledged as collateral in connection with the mortgage conveyed by the Hospital to the Authority. The Hospital has also granted to the Authority a first lien on certain defined gross receipts (including related accounts receivable) as additional collateral for payment of the mortgage.

The mortgage agreement provides for payment, to funds held in trust, of an initial deposit of principal and interest and subsequent monthly payments in amounts proportionate to the Authority's (a) annual principal payments on sinking fund installments, ranging from $475,000 in 1981 to $525,000 in 2005 and (b) semiannual interest payments at rates varying from 4.9% to 5.7% over the lives of the bonds. Debt service on the bonds is paid from the funds held in trust.

In 1980, the Hospital refinanced an existing bank loan. New financing was obtained from the proceeds of the sale by the Authority of New England Deaconess Hospital, Series B, Revenue Bonds in the amount of $1,800,000, with principal and interest at an annual rate of 8¼% payable monthly through April 1, 1990. The financing is collateralized by a mortgage on the Hospital's 1979 parking garage addition.

The Authority also loaned the Hospital the proceeds from the sale of an additional Series B bond in the amount of $725,000 which is payable in monthly installments through April 1, 1985 and bears interest at an annual rate of 9%. The proceeds were used to purchase certain equipment which is pledged as collateral.

Long-term debt at year end is summarized as follows:

	1981	1980
New England Deaconess Hospital Issue, Series A	$11,135,000	$11,835,000
Less unamortized discount	164,350	175,417
Net	10,970,650	11,659,583
New England Deaconess Hospital Issue, Series B	1,880,907	2,155,254
Total long-term debt—net	$12,851,557	$13,814,837

5. Endowment Funds Mortgage Note Payable

The endowment funds mortgage note bears interest at 5¼% and is payable in monthly installments through January 1991, including, at September 27, 1981, $136,000 due within one year. The Medical Office Building is assigned as collateral under the terms of this mortgage.

6. Employees' Retirement Plan

The Hospital has a noncontributory defined benefit retirement plan covering all employees working 1,000 hours or more per year. Total pension expense aggregated $2,800,000 in 1981 and $1,950,000 in 1980, including amortization of the unfunded actuarially computed past service liability over a ten-year period in 1981 and a forty-year period in 1980.

The effect of the change in the amortization period in 1981 was to increase pension expense by approximately $600,000 in 1981. The Hospital makes annual contributions to the pension plan equal to the amounts accrued for pension expense.

A comparison of accumulated plan benefits, determined using an assumed rate of return of four percent, and plan net assets as of the date of the most recent actuarial valuation, October 1, 1980, is as follows:

Actuarial present value of accumulated benefits:	
Vested	$12,868,000
Nonvested	2,300,000
Total	$15,168,000
Net assets available for benefits	$12,835,000

7. Malpractice and Comprehensive Liability Insurance

Effective April 1, 1976, the Hospital changed its malpractice and comprehensive liability insurance coverage from an occurrence basis policy to a claims-made policy. The claims-made policy, which is subject to renewal on an annual basis, covers only claims actually made during the term of the policy, but not those occurrences for which claims may be made after expiration of the policy.

8. Interfund Transfers

During 1980, the Hospital's management and its legal counsel performed a comprehensive review of the terms of certain of its restricted funds. As a result, certain funds were transferred between restricted and unrestricted funds to more closely reflect the current interpretation of the terms of the original gifts.

9. Lease Information

The Hospital leases certain equipment under operating leases, many of which contain renewal options. Total rental expense under such leases amounted to approximately $1,005,000 and $668,000 for 1981 and 1980, respectively.

Auditors' Opinion

New England Deaconess Hospital:

We have examined the balance sheets of New England Deaconess Hospital as of September 27, 1981 and September 28, 1980 and the related statements of revenues and expenses, changes in fund balances, and changes in financial position of unrestricted funds for the fiscal years (52 weeks) then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, such financial statements present fairly the financial position of the Hospital at September 27, 1981 and September 28, 1980 and the results of its operations, changes in its fund balances, and changes in the financial position of its unrestricted funds for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Deloitte Haskins & Sells

Boston, Massachusetts
November 13, 1981

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